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Nurses' Decision-Making in Termination of Pregnancy Services at Health Care Facilities in the Western Cape

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Preamble

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Dedication

This thesis is dedicated to all the women who have tried to make use of their right to choose.

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Abstract

Using the theory of “street-level bureaucrats”, this thesis examines the implementation of the South African Choice on Termination of Pregnancy Act by exploring nurses’ decision-making in termination of pregnancy services. As front-line providers, nurses play a critical role in the implementation of termination of pregnancy services. Nurses may be required to assist in informing, preparing or counselling women who request a termination of pregnancy and, if appropriately trained, nurses can perform terminations of pregnancy. Research suggests, however, that 15 years after the promulgation of the law, nurses continue to be reluctant to participate in termination of pregnancy services thereby undermining the successful implementation of the Choice on Termination of Pregnancy Act.

The thesis is divided into three distinct sections. The first part of the thesis (Part A) is the research protocol which was submitted to the Faculty of Health Sciences Research Ethics Committee for approval. The research protocol describes in detail the justification for and methodology of the qualitative study on nurses’ decision-making in the provision of termination of pregnancy services. The second part of the thesis (Part B) is a short literature review which identifies and summarises key literature on policy implementation theory and the implementation of the Choice on Termination of Pregnancy Act. The final part of the thesis (Part C) is a “ready-for submission” manuscript of a journal article for submission to *Social Science and Medicine*. The manuscript reports and analyses key findings of the research. It has been formatted according to the journal’s guidelines for authors which are, together with other appendices, attached to the thesis.

Acknowledgements

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Thank you to the Western Cape Department of Health for approving the research. I am indebted to the Sisters and nurses who participated in the interviews. Thank you for sharing your views so openly and taking the time to speak to me despite having such busy schedules.

Finally, I am of course thankful to my husband Piet who already supported me through my legal dissertation and now had to go through the motions again with this mini-thesis. Thank you!

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Part A:

Research Protocol

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**Nurses' Decision-Making in Termination of
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I. Introduction

When the first democratic government was elected in South Africa in 1994, the need for legislative reforms and structural adjustments was enormous in virtually all sectors of public policy. It may therefore seem surprising that access to legal and safe termination of pregnancy (TOP)¹ was one of the first issues tackled by this first democratically elected government. However, despite having been one of the first public health laws of the “new” South Africa, research suggests that the implementation² of the Choice on Termination of Pregnancy Act (CTPA) still remains a challenge 15 years after its promulgation (Harrison et al., 2000; Klugman & Varkey, 2001).

The implementation of the CTPA, like the implementation of other health policies, very much depends on the behaviour of those charged with implementing the law on the ground. Front-line providers, also called “street-level bureaucrats”, arguably have a major impact on policy implementation because they develop their own “operating routines” and “invent their own rules” to manage their workload and make decisions about who receives a service and who does not (Hudson & Lowe, 2004; Walker, 1993; Walt & Gilson, 1994). Street-level bureaucrats further affect the implementation of laws and policies by deciding *how* they render a service (Maynard-Moody & Musheno). Implementation of the CTPA thus depends on the behaviour of front-line providers such as nurses. The proposed study, therefore, suggests

¹ This protocol uses the terms “abortion” and “termination of pregnancy” interchangeably.

² This protocol uses a wide understanding of the term “implementation” that includes not only *whether* services under the law are provided, but also *how* these services are provided.

exploring nurses' decision-making in terms of providing and assisting with TOP services.

II. Problem Statement

Nurses' support of TOP services is crucial for the implementation of the CTPA because of their role as providers of TOPs and as assistants to providers. To promote access to abortions, the CTPA allows nurses who have received appropriate training to perform first trimester TOPs. In addition, nurses may be required to prepare the patient for the TOP, for instance by administering medication for cervical priming or providing TOP counselling, and to assist doctors or other nurses during the TOP. However, nurses have repeatedly been reported to be unwilling to conduct or participate in TOPs (Harries et al., 2007; 2009; Jewkes et al., 2005) which acts as a barrier to women's access to TOPs and hence constitutes an obstacle to the implementation of the CTPA. Despite nurses' general opposition to TOPs, under certain circumstances nurses may be willing to assist women requesting abortions, for instance if the pregnancy is the result of a rape or if the foetus has congenital abnormalities (Harries et al., 2009; Mokgethi et al., 2006). The fact that nurses are comfortable with assisting in TOPs under certain circumstances suggests that abortion lends itself to *normative* decision-making and that nurses make value judgments about their clients. Harrison et al. (2000) suggest that nurses create a "hierarchy of support" under which certain clients are considered more worthy of support than others. It remains unclear though how nurses make decisions about providing or assisting in TOP services and how personal norms and values affect this decision-making process. This research

therefore explores the decision-making of nurses regarding their involvement in the provision of TOP services.

III. Justification

Given that the implementation of the CTPA depends on the support of nurses as front-line providers, it is important to understand how nurses make decisions about whether or not they assist in TOP services and which clients they consider worthy of support. To date, few studies explore nurses' role in the implementation of the CTPA and those that do, focus on nurses' attitudes rather than on their decision-making processes (Engelbrecht, 2005; Harries et al., 2007; 2009). The proposed research aims to make a contribution to the existing literature by examining how personal value or belief systems affect nurses' decision-making. Exploring this process will assist us in understanding current barriers to the successful implementation of the CTPA and in developing targeted interventions to improve policy implementation. The proposed research will also make an important contribution to building theory on health policy implementation in a developing country, given that current literature on policy implementation theory focuses on high-income, Western countries (Walt et al., 2008). The study will be the first work that applies the theory of Maynard-Moody & Musheno (2003) which was developed to understand the decision-making of policy implementers such as police officers, teachers and counsellors, to a new group of policy implementers, namely nurses working at hospitals offering TOPs in the Western Cape.

IV. Research Question

The purpose of the research is an in-depth exploration of the following question:

How do personal norms and values affect nurses' decision-making in relation to providing or assisting in TOPs?

The research will be limited to nurses working at hospitals offering TOPs in the Western Cape.

V. Objectives

The objectives of the study are:

- To explore nurses' views on TOP services including the legality of TOPs and implementation challenges of the CTPA;
- To explore how nurses make decisions about providing or assisting in TOPs;
- To explore how nurses' decision-making and their subsequent decisions may affect the implementation of the CTPA.

VI. Study design

The research is part of a larger qualitative study which examines nurses' role in the provision of reproductive health care services.³ However, the thesis research focuses on nurses' decision-making in relation to TOP services.

³While the larger study is limited to teenagers, the thesis research is not.

1. Methods

Following the model developed by Maynard-Moody & Musheno (2003) the proposed study will use in-depth interviews to explore how the value systems of nurses influence y their decision-making in relation to TOP services. The interviews will be conducted face-to-face using a semi-structured questionnaire (Appendix A) with open-ended questions. Given that front-line providers' value systems and understanding of fairness are "never fully articulated", participants will also be asked to share a "story" about a particular TOP client that had an impact on their views of TOPs (Maynard-Moody & Musheno, 2000). The questionnaire will also include questions on other factors that might influence nurses' willingness to participate in abortion services such as their work environment, workload, general rules and procedures, and relationships with other health care providers. The interview will be conducted in English. While English may not be the mother tongue of all participants, it is the language in which most nurses in the Western Cape receive their formal nursing training. Language barriers should therefore be minimal. The interview will take approximately 45 minutes.

2. Population and sampling

The study will be conducted among registered nurses, including professional nurses and enrolled nurses, who work at hospitals that offer TOPs in the Western Cape. Given that the purpose of the study is to understand complex decision-making processes, the study will make use of a convenience sample which will yield a smaller number of information-rich interviews. The number of interviews also needs to be limited to match the scope of the project's

requirements. In-depth interviews will therefore be conducted with six nurses. Up to two interviews may be conducted at the same facility.

For the purpose of this study, it is irrelevant whether the interviewees have undergone specific training that allows them to conduct TOPs by themselves. Even those nurses who do not perform the abortion itself may be asked to assist doctors who are performing TOPs. Furthermore, before a TOP can be performed certain other health services need to be undertaken by nurses, such as administering drugs for cervical priming; abortion counselling; informed consent, or general tasks such as checking blood pressure. Nurses may also be asked to assist in post-abortion care (e.g. handing out pain medication; checking for bleeding; etc.). These related tasks force even those nurses who are not involved in the TOP itself to make decisions about the circumstances under which they would, or would not, assist a patient who requests a TOP. Nurses are, furthermore, required to inform patients who enquire about TOPs about the possibility of having an abortion and at which facility they can obtain a TOP. Not being trained to carry out abortions is therefore not an exclusion criterion.

VII. Data Management

The interviews will be recorded and subsequently transcribed verbatim. Notes will also be taken during the interview; these will be transferred into an electronic format as soon as possible after the interview. All data (handwritten notes, tape recordings, and transcripts) will be filed appropriately and stored securely where they can be accessed only by the researcher. The data will

not be destroyed after the conclusion of the study, but will be filed and stored in a secure place at the research unit which conducts the larger study of which this project forms a part.

VIII. Data Analysis

The data analysis will draw on narrative analysis theory. According to Thorne, “narrative analysis is a strategy that recognises the extent to which the stories we tell provide insights about our lived experiences” (Thorne, 2000). Narrative analysis looks for “the main narrative themes within the accounts people give” and uses these themes to show how the storyteller understands and makes sense of different aspects of their life, including personal relations, work, and daily routines (Thorne, 2000). In addition, the data will be analysed thematically by identifying themes across the interviews. Given that the interviews will be conducted in English, which may not be the mother tongue of all participants, the researcher should be cautious of language barriers when using narrative analysis. Furthermore, when using narrative analysis, it should be taken into account that stories may not provide a full understanding of participants’ experiences; narratives often only provide “pieces for a mosaic or total picture” (Marshall & Rossman, 1995).

IX. Write-up

The final phase is writing up the findings which will include a reflection on the analysis of the data. The findings will be written up in a journal article format to allow for submission to an academic journal for publication.

X. Logistics

After having obtained ethical clearance from the Research Ethics Committee at the Faculty of Health Sciences (University of Cape Town), approval from the Western Cape Department of Health will be sought. Once this approval has been granted, a list of health care facilities providing abortions in the Western Cape will be obtained from which to select the convenience sample. In preparation for the fieldwork, managers of health care facilities that provide TOP services will be informed of the study and asked for permission to conduct an interview with one or two nurses at the facility. Once approval has been granted by the facility, the nursing manager of the facility will be informed of the research and asked for the most convenient day and time to conduct the interview to minimise the impact of the research on scarce human resources. The researcher will conduct an interview with a nurse who is on duty at the arranged date and time. Interviews will be conducted in English in a private room at the participant's workplace.

XI. Limitations

Participating nurses may be wary of the motives of the researcher and thus reluctant to be open during the interview, particularly given that the topic of the research is highly contentious. The interview will therefore be structured in a way that builds rapport between the researcher and the participant by beginning the interview with general questions before asking about TOP services. Nurses may also be reluctant to be open about not following policy. This limitation will be minimised by explaining the purpose of the research to the participants and by highlighting that the data will be kept confidential and

the findings of the research will be reported anonymously. Previous studies by the researcher have also shown that front-line providers often appreciate the opportunity to explain to someone the complexities of their work. Being an outsider could also be a benefit because nurses may feel more confident speaking to someone who is not part of their organisation or their employer.

Furthermore, the researcher needs to be sensitive to “the potential influence of the analyst’s own values and perspectives over the analysis” (Walt et al., 2008). Every effort will be made to avoid personal views and beliefs throughout the research process to minimise the impact on data analysis. Finally, due to the small sample size and the geographic focus on the Western Cape, the findings of the study will not be generalisable. The research is explicitly qualitative in nature and not meant to yield generalisable data.

XII. Ethics

The study proposal will be submitted to the University’s Research Ethics Committee and the Western Cape Department of Health for approval.

Before conducting the interview, the researcher will verbally explain the purpose and nature of the study to the interviewee and will hand the interviewee an information sheet which includes the contact details of the researcher and of the University’s Research Ethics Committee (Appendix B). It will be emphasised that participation in the study is voluntary and that the study is not aimed at evaluating the participant’s performance, but at

understanding his or her work load, work environment and decision-making processes in relation to abortion. The interviews will be limited to 45 minutes to minimise strain on scarce human resources.

Participants will be informed that the research has been authorised by the Department of Health and the hospital manager, but that their participation in the study is completely voluntary and that they have the right to withdraw the consent or stop the interview at any time without prejudice. The researcher will, furthermore, reassure participants that the information they provide will be kept confidential and that their identity and identifying details will not be revealed in any manner, including in the publication of the research. Participants will also be informed that they will not receive a financial incentive/reimbursement for their participation because the interviews are conducted during their work time at their workplace. After explaining the study and addressing all questions of the interviewee, participants will be asked to sign a consent form (Appendix B).

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Part B:

Literature Review

**Nurses' Decision-Making in Termination of
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I. Introduction

The literature review serves as a backbone to the proposed project on nurses' decision-making in the provision of termination of pregnancy (TOP) services. The objective of the literature review is to critically evaluate studies relating to the implementation¹ of the Choice on Termination of Pregnancy Act (CTPA). In light of the crucial role of nurses in the implementation of the law, the literature review focuses on nurses as policy implementers or "street-level bureaucrats".

Literature was identified through an incremental search strategy with a variety of search terms (e.g. "abortion AND South Africa"; "termination of pregnancy AND South Africa"; "Choice on Termination of Pregnancy Act"; "nurses AND abortion"; etc.). In addition to electronic searches in the PubMed database and Google Scholar, a search was conducted in Google to find papers that have not been published in peer reviewed journals. Articles published in journals that were not accessible electronically (e.g. *Curationis*) were accessed through hard copy journals. Only studies that were conducted after the enactment of the CTPA were included in the literature review, given the focus of the project. While a number of studies that address different aspects relating to the implementation of the CTPA were identified, only a limited number of studies focus on the role of nurses in the implementation process (Botes, 2000; Engelbrecht, 2005; Harries et al., 2007; 2009; Mokgethi et al., 2006). In light of the paucity of studies on nurses, the literature review also includes studies that deal with other aspects of implementation of the CTPA.

¹ This literature review uses a wide understanding of the term "implementation" that includes not only *whether* services under the law are provided, but also *how* these services are provided.

The first part of the literature review provides an overview of the CTPA and describes the responsibilities of health care workers such as nurses under the law. The second part of the literature review briefly sets out the relevant theoretical frameworks used to analyse policy implementation. The third part of the literature review discusses existing research on the implementation of the CTPA.

II. The Choice on Termination of Pregnancy Act

1. Overview of the law

The CTPA was one of the first laws enacted by South Africa's democratically elected government in 1996. Klugman and Varkey (2001) have comprehensively described the policy process, including the strategies employed by women's rights groups that led to the enactment of the CTPA. It bears repeating though that women's rights activists capitalised on the international and national human rights discourse which emphasised the need for the advancement of women's rights (Cooper et al., 2004). The introduction of the Primary Health Care approach by the new South African government further promoted health as a human right and was geared at "redress[ing] past neglect of the health needs of poor, black women" (Cooper et al., 2004). Women's rights activists took advantage of this window of opportunity and advocated for a liberal abortion law that would reduce maternal morbidity and mortality by providing safe, legal and accessible TOPs for all women. Through strategic alliances these activists succeeded in getting a pro-choice abortion

law passed that the majority of South Africans actually did not support (Klugman & Varkey, 2001).

The CTPA is a major shift from the old Abortion and Sterilisation Act of 1975 under which abortion was only allowed under very narrow circumstances (e.g. after having been raped or if the mental or physical health of the mother was at risk) and where the termination required the approval of an independent doctor (Guttmacher et al., 1998). Under the CTPA any pregnant woman or girl can request a TOP in the first trimester, without consultation or approval by a doctor or nurse (section 2(1)(a) of the CTPA). The law explicitly states that its provisions apply to “any female person of any age” (section 1 of the CTPA), which means that minors do not require parental consent to have a TOP. While health care professionals should advise minors to consult their parents before having an abortion, they may not deny the TOP because the minor chooses not to consult them (section 5(3) of the CTPA). One of the reasons for not requiring parental consent was that pregnant minors may have been sexually abused by their father or guardian and parental consent could therefore “pose a barrier to seeking help” (Mhlanga, 2003). The law states that pre and post abortion counselling should be made available, but it is not mandatory for clients to undergo such counselling to have an abortion (section 4 of the CTPA). The CTPA is thus very clear that TOPs in the first trimester are the autonomous decision of the consenting pregnant woman or girl and are not subject to any other conditions.

Under certain conditions, females can request a TOP between 13 and 20 weeks of gestation if:

- the pregnancy is the result of a rape or incest;
- the foetus is at risk for severe mental or physical abnormality;
- there is a substantial risk to the physical or mental health of the pregnant woman in continuing the pregnancy; or
- the pregnancy would significantly affect the social or economic circumstances of the pregnant woman (section 2(1)(b) of the CTPA).

For these second trimester abortions the pregnant woman needs to consult a medical practitioner, i.e. a medical doctor (section 2(1)(b) of the CTPA). Whereas first trimester TOPs can be carried out by doctors as well as by appropriately trained midwives and nurses, abortions in later trimesters can only be performed by medical practitioners (section 2(2) of the CTPA). Abortions are made available at health care facilities that have been designated by the Minister of Health or that are sufficiently equipped and have a 24-hour maternity service (section 3(3)(a) of the CTPA).

2. The role of health care workers

The CTPA deliberately does not introduce an obligation for medical practitioners, midwives and nurses to perform or participate in abortions because TOPs may conflict with health workers' moral norms or religious or cultural beliefs (Klugman & Varkey, 2001). In fact, a provision forcing health workers to participate in TOPs was removed from the draft law to ensure that the law would receive a majority vote in Parliament (Klugman & Varkey, 2001).

Thus health workers' rights are given equal protection to women's rights (Klugman & Varkey, 2001). Medical practitioners, midwives and nurses do, however, have a legal duty to inform a pregnant woman or girl who requests a TOP about their right to have the pregnancy terminated (section 6 of the CTPA). The Regulations under the Choice on Termination of Pregnancy Act (i.e. the "operational guidelines") published by the Department of Health in terms of section 9 of the CTPA, further concretise the duties of health care professionals. According to these Regulations, informing a woman or girl about her rights must include the following information:

- Her right to terminate a pregnancy on request during the first 12 weeks;
- That only the woman's consent is required for the procedure during the first 12 weeks of pregnancy;
- That the pregnancy may be terminated between the 13th and the 20th week under certain circumstances;
- That counselling is available;
- The location of a facility that renders TOP services.

The Regulations further stipulate that if the patient is a minor, she should also be advised to consult her parents, guardian, family members or friends before the pregnancy is terminated, but the health worker must inform her that the termination will not be refused if she chooses not to consult anyone. Under the CTPA and the Regulations, the provision of information is the only explicit legal duty of health care professionals. While the Regulations require health care professionals to specify the location of a designated centre they do not

mandate making a proper referral to that facility by writing a referral letter or contacting the facility to arrange an appointment for the client (Klugman & Varkey, 2001). Additional duties of health care professionals relating to abortions may stem from the Constitution. For instance, health workers' constitutional duty to assist patients who are in an emergency situation may apply in certain situations (Ngwena, 2003).

The CTPA thus creates a right to choice for the first 12 weeks of the pregnancy, but does not clarify how this right will be put into practice. The CTPA does not include an obligation for health workers to participate in TOP services or to give reasons for their conscientious objection to TOPs. The law also fails to regulate the provision of training for health workers. Whereas other laws, such as the Criminal Law (Sexual Offences and Related Matters) Amendment Act, attempt to improve policy implementation by obligating the Department of Health to train health workers on the law, the CTPA neither requires the Department of Health to offer training on the law nor “value clarification workshops” which are aimed at transforming abortion-related attitudes and behaviours. The law seems to have been drafted with the underlying assumption that once it is enacted, ongoing advocacy will ensure its implementation. However, as will be argued below, various obstacles prevent the successful implementation of the CTPA thereby limiting the right to terminate a pregnancy.

III. Policy implementation theories

Various frameworks have been developed to examine the implementation of public policy, such as the CTPA, including the opposing “top-down” and

“bottom-up” implementation theories. According to “top-down” theories, implementation of public policy is a technical process that works from the (top) political level down to the front-line providers who are charged with implementing the policy on the ground. Proponents of the “top-down” theory argue that policy is formulated and decided by politicians at national level and is then translated into operating instructions which public service workers will follow (Hudson & Lowe, 2004). Lack of implementation is thus seen as front-line providers not doing their job properly which can best be addressed by “stricter enforcement and tighter appraisal of the administrative machine” (Hudson & Lowe, 2004). Top-down theories have been rightly criticised as “naïve” for assuming that implementers simply follow orders and act rationally (Hudson & Lowe, 2004).

The theories that follow the “bottom-up” approach see policy implementation as an integral element of policy change and suggest that the power lies with the implementers of public policy because human agency determines policy implementation (Hudson & Lowe, 2004). Lipsky (1971), for instance, argues that policy is not the product of policy-makers, but rather what is implemented on the ground constitutes (the real) policy. Public service workers thus make policy by using their discretion and acting upon their own understandings of policy.

Within this school of thought, the theory of “street-level bureaucrats” proposes that public service workers have a major impact on policy implementation because they develop their own “operating routines” and “invent their own

rules” to manage their workloads (Hudson & Lowe, 2004). Maynard-Moody & Musheno (2003) go a step further by suggesting that the very nature of their work in fact requires front-line providers to exercise their discretion to find the most appropriate response to their clients. The conduct of front-line providers is therefore not only influenced by rules or procedure, but also by beliefs and norms about what is fair or the “right” thing to do (Maynard-Moody & Musheno, 2003; Walker, 1993). To decide whether a client is “worthy” of a particular service, public sector workers rely on value judgments (Maynard-Moody & Musheno, 2003). Personal norms and value systems become particularly important when front-line providers operate in challenging work environments. For instance, if street-level bureaucrats are required to implement policy in an unsupportive setting, such as work environments that lack resources, managerial communication and/or collegial support, they are forced to make decisions about how they provide a service based on their personal value systems (Maynard-Moody & Musheno, 2003; Moulton 2010; Walker & Gilson, 2004.) The environment in which street-level bureaucrats work and the day-to-day challenges they face therefore shape their decision-making when implementing policy.

Personal value judgments and attitudes of street-level bureaucrats play an important role when they make a decision about whether and, if so, how they are going to assist a particular client. Value judgments are shaped by beliefs, ideals and knowledge (Turner et al., 2008). Turner et al. (2008) argue that value judgments affect an individual’s decision-making process and consequently their behaviour because when making decisions people draw on

their values as an “internal roadmap”. Existing research on street-level bureaucrats supports this theory. Maynard-Moody & Musheno (2003) found that services rendered by teachers, police officers and vocational counsellors are influenced by their values and attitudes towards their clients. Similarly, Moulton (2010) highlights that clerks of the court base their decision on the kind of assistance they provide to clients based, on large part, on their personal norms and what they perceive to be the best (moral) outcome for the client. It is therefore not surprising that interventions addressed at changing attitudes of public workers can lead to behavioural changes. For instance, “value clarification workshops” aimed at transforming abortion-related attitudes and behaviours of health care workers have been successful in winning support for TOP services among health care professionals (Turner et al., 2008).

Although nurses like other front-line providers of government-funded services actively influence the implementation of health policy by deciding who receives a service and who does not and how a particular service is provided, thus far only very few South African studies examine the role of nurses as “street-level bureaucrats” in policy implementation (Walker & Gilson, 2004). The proposed study will therefore contribute to closing this gap in the literature.

IV. The implementation of the Choice on Termination of Pregnancy Act

The CTPA has clearly had a positive impact on women’s health. In the first six months after the enactment of the CTPA, the number of safe legal abortions in public health care facilities was already double the number of legal

abortions conducted over *seven years* (1984 to 1991) under the previous legislation (Kustner, 1991) and the number of legal abortions increased from 26,455 in 1997 to 68,736 in 2010 (Healthlink, n.d.). Furthermore, several studies demonstrate that since the introduction of the CTPA, abortion-related morbidity and mortality have dropped dramatically (Brown, 2002; Jewkes & Rees, 2005; Jewkes et al., 2002; Jewkes, Rees, Dickson, Brown, & Levin, 2005). Pregnant women and girls have thus gained health benefits from the liberal abortion law. However, despite the positive impact on mortality and morbidity, various factors continue to hinder the implementation of the CTPA.

1. Knowledge of the law

Particularly in the first few years after the CTPA came into effect, many women did not know about their rights. The South African Demographic Health Survey of 1998 showed that only 53% of women were aware that abortions up to 12 weeks of pregnancy were legal (Department of Health, 1998). In more recent studies, knowledge about the legality of TOPs has improved. For example, two-thirds of 831 female patients at clinics in the Western Cape and 69% of adolescents in KwaZulu-Natal knew that TOP was legal (Morrone et al., 2006; Varga, 2002). However, in both studies women and youths in rural areas were significantly less likely to know about the option of legal abortions (Morrone et al., 2006; Varga, 2002). The lack of knowledge among adolescents is particularly worrying given the high rates of teenage pregnancy in South Africa (Pettifora et al., 2005). Lack of awareness of the legality of TOPs thus continues to be a barrier to accessing TOPs for rural women and girls.

Another barrier to TOPs may be nurses' lack of knowledge of the CTPA. While 97% of 100 nurses interviewed for a study in the Free State knew that TOP is available on request in the first trimester and 75% knew that second trimester abortions are allowed if the continued pregnancy would significantly affect the pregnant woman's social or economic well-being, nurses were less familiar with other aspects of the CTPA (Engelbrecht, 2005). For instance, a quarter of the nurses (24.2%) were not aware that under special circumstances an abortion is allowed beyond 20 weeks of pregnancy and 25.3% of the nurses believed that minors need parental consent before having an abortion (Engelbrecht, 2005). The uncertainty regarding these aspects may thus act as a barrier for minor TOP clients or women requesting an abortion beyond 20 weeks of pregnancy.

2. Lack of facilities providing abortions

In addition to the lack of knowledge of the law among potential clients and providers of TOPs, access to TOP services may be obstructed by a lack of facilities offering TOPs. Whereas in 1999, only a third of the health care facilities designated to provide abortions actually offered abortions (Dickson et al., 2003), almost two-thirds (61.8%) of designated facilities were providing TOPs in 2003 (Healthlink, n.d.). In 2009, the Department of Health reported that 45% of community health centres (i.e. facilities that are more advanced than clinics, but not as well-equipped as hospitals) across the country now provide TOPs (Department of Health, 2009). Given that "one of the key equity intentions" of the CTPA was to offer first trimester abortions at primary health care level (Klugman & Varkey, 2001), a coverage of 45% at community health centres, albeit 15 years after the promulgation of the CTPA, is certainly not a

success. Furthermore, TOP services continue to be more accessible in urban areas (Braam, 2002). The lack of TOP services results in long waiting times and in women being turned away at hospitals designated for TOPs (Harries et al., 2009). The delays caused by long waiting times for abortion appointments also result in high numbers of second trimester abortion requests which is concerning because health risks are higher in second trimester abortions (Harries et al., 2007).

3. *Nurses' attitudes towards abortions*

Doctors' and nurses' resistance towards TOPs remains one of the biggest challenges to the implementation of the CTPA. In the first years after the enactment of the CTPA, hospital administrators failed to nominate staff for TOP training thereby delaying access to TOP services (Hord & Xaba, 2002; Mhlanga, 2003). Doctors expressed their opposition to TOPs by refusing to participate in training on surgical TOP techniques – a procedure which is not included in general surgical training – and to attend “value clarification workshops” which were offered in the first years after the CTPA was enacted and were meant to engage health workers in a process of self-examination with the goal of transforming abortion-related attitudes and behaviours (Klugman & Varkey, 2001; Mhlanga, 2003).

Research suggests that nurses tend to categorise women who request abortions into those who are worthy and those who are unworthy of support (Harries et al., 2007; Harrison et al., 2000; Mokgethi et al., 2006). Based on this categorisation, nurses create a “hierarchy of support” for TOP clients which may affect levels of care (Harrison et al., 2000). For instance, many

nurses are supportive of rape or incest survivors having an abortion (Harries et al., 2009; Harrison et al., 2000; Mokgethi et al., 2006). If the unborn child has congenital abnormalities, nurses also feel that choosing a TOP is reasonable or understandable (Harries et al., 2009; Mokgethi et al., 2006). In these situations, abortions are constructed as “justified” because these circumstances of a pregnancy are regarded as “tragedies” that make the patient worthy of support (Harrison et al., 2000).

Nurses are, however, opposed to women having repeat abortions because they feel that such women are using abortion as a form of contraception, which in their view is unacceptable (Harries et al., 2009; Mokgethi et al., 2006). Twenty-three of 25 nurses in a study in the North West province thought that women should not be allowed to have repeat abortions (Mokgethi et al., 2006). Sixty-nine percent (n=69) of nurses in a study in the Free State thought that people have become more careless with contraception since the introduction of the CTPA (Engelbrecht, 2005). Fears of women “abusing” the law or becoming immoral as a result of the CTPA were also expressed by participants in Harrison et al.’s study (2000) where one nurse explained that women just “want to enjoy sex” and do not care if this sex will lead to an unwanted pregnancy (Harrison et al., 2000). Nurses thus clearly make value judgments about the “moral character” of the woman requesting the TOP.

Reports from the provincial Departments of Health suggest that in the first few years after the introduction of the CTPA nurses were particularly judgmental towards teenagers seeking abortions (Braam, 2001). Half of the nurses (n=53,

53%) in Engelbrecht's study (2005) thought that there should be stricter rules for girls under the age of 18 accessing abortions and that minors should be required to obtain parental consent (n=49, 49%). These attitudes are worrying because access to TOPs for teenagers is crucial given the high rates of teenage pregnancy and the fact that many of these pregnancies are unwanted (Pettifora et al., 2005). One of the objectives of the CTPA is therefore precisely to protect teenagers from unwanted pregnancies. The judgmental attitudes towards teenagers accessing abortions are furthermore surprising given that there is no evidence that teenagers have become more careless in terms of their sexual behaviour since the introduction of the CTPA (Braam, 2001; Buchmann et al., 2002).

Another factor limiting nurses' willingness to be involved in abortions is the interpretation of abortions as "killing" another human being. As one nurse suggested, "Mandela has given them this right, now they are going to kill because they want to enjoy sex" (Harrison et al., 2000). Nurses providing or assisting in TOPs are thus seen as accomplices in the "killing" of another human being (Harrison et al., 2000). Interestingly, completing an incomplete abortion, on the other hand, was interpreted differently. In this case nurses "felt that the stigma associated with the abortion would be placed on the woman receiving care, who had started the abortion, rather than on the nurse, who was simply fulfilling [sic] professional duty in saving a life" (Harrison et al., 2000).

TOP clients clearly get to feel nurses' negative attitudes towards TOPs. As one participant in the study by Harries et al. (2007) explained:

You feel like they are just looking at you, they're just looking at someone who is cheapskate, who doesn't have any morals. Someone who thinks, okay, fine, I'm going to fall pregnant today, tomorrow I'm going to take it out. But what they don't understand is – it's not that simple to come to that kind of a decision.

As a result of the negative attitudes towards TOPs, some nurses try actively to undermine access to TOPs by failing to inform women of the location of the nearest TOP facility or attempting to dissuade women from going through with an abortion (Harries et al., 2007; 2009; Jewkes, Gumedde, Westaway, Dickson, Brown, et al., 2005).

4. *Stigma of abortions*

Another problem in the provision of abortion services is that those nurses who are involved in TOP services lack support from their colleagues in the work environment. Nurses who perform abortions report harassment and negative attitudes from colleagues (Varkey et al., 2000). As one health care worker in Varkey et al.'s (2000) study explained: "Their attitude affects me. At times I tell myself that they are ignorant, why should I be offended. However, at times they break you". While the majority of health care workers in a study in the Free State had not experienced stigma from their peers, a small proportion of nurses indicated that they were sometimes harassed by their colleagues, with one participant explaining, "they call me names, and say that we are killers"

(Engelbrecht, 2005). Furthermore, eight out of 23 nurses in this study mentioned “regularly or sometimes” feeling isolated from colleagues not doing TOPs because these colleagues would disapprove of them rendering abortions and would not invite them to staff activities (Engelbrecht, 2005). Another study reported that some nurses do not want to enroll in abortion training because participating in such training is seen as taking a pro-choice stance (Harries et al., 2009). This suggests that some nurses assisting in TOPs may feel harassed and isolated in the workplace which may – in the long-term – lead to nurses stopping provision of these services. In addition, the lack of a supportive work environment may further limit access to TOP services by discouraging nurses from getting involved in abortion services.

V. Conclusion

The CTPA has resulted in a decrease of maternal mortality and morbidity by giving women and girls the right to make autonomous decisions about their reproductive health. As “street-level bureaucrats”, nurses play an important role in the provision of TOPs both as providers and assistants to doctors or nurses performing abortions. However, in addition to other barriers, the current lack of support for TOPs among nurses constitutes an obstacle to the successful implementation of the CTPA. Existing research suggests that nurses distinguish deserving patients from less- or undeserving patients thereby creating a “hierarchy of support” for TOP clients and affecting the implementation of the CTPA. Yet, to date there is a paucity of studies exploring nurses’ decision-making in TOP services, particularly how underlying value-systems shape nurses’ decision-making. Understanding

nurses' decision-making is critical to improving the implementation of the CTPA and therefore this gap in the literature urgently needs to be addressed.

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Part C:

Manuscript for Social Sciences & Medicine

**Nurses' Decision-Making in Termination of
Pregnancy Services at Health Care
Facilities in the Western Cape**

Cover page

Title

Nurses' Decision-Making in Termination of Pregnancy Services in South Africa – Do Norms and Values Count?

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Keywords

Termination of pregnancy; policy implementation; street-level bureaucrats; nurses' decision-making; South Africa.

Nurses' Decision-Making in Termination of Pregnancy Services in South Africa – Do Norms and Values Count?

Abstract

Nurses, like other public service workers, make moral judgments about clients accessing termination of pregnancy services. In this study, whereas certain clients were constructed as worthy of support, others were seen as unworthy of support. Nurses were empathetic towards women whose pregnancy was forced upon them and accepted terminations of pregnancy for a one-time “slip-up”. Women coming for repeat abortions, however, were constructed as irresponsible for using termination of pregnancy as a method of family planning. Constructions of women accessing termination of pregnancy services also need to be interpreted in the context of unsupportive work environments. Colleagues of nurses providing termination of pregnancy are unsupportive of their work. Despite these constructions, the participants in this study claim that there are no differences in the services offered to clients considered worthy or unworthy of support. However, further research on the level and quality of TOP services and on nurses who refuse to assist in termination of pregnancy services is required to confirm these results.

Background

The theory of street-level bureaucrats proposes that public service workers, such as teachers or criminal justice personnel, have a major impact on policy implementation because they develop their own operating routines and day-to-day processes to manage and simplify their workloads, especially in under-

resourced settings (Hudson & Lowe, 2004; Maynard-Moody & Musheno, 2003). Front-line providers must exercise discretion in responding effectively to the variable needs of their clients (Walker & Gilson, 2004). The behaviour of these front-line providers is not only influenced by rules or procedure, but also by beliefs and norms about what is fair (Maynard-Moody & Musheno, 2003; Walker, 1993). Personal norms are particularly important when front-line providers operate in challenging policy environments. For instance, if street-level bureaucrats are required to implement policy in a work environment that lacks resources, managerial communication and collegial support, they are forced to make decisions about who receives a service and how this service is provided based on their personal value systems (Maynard-Moody & Musheno, 2003; Moulton 2010). Maynard-Moody and Musheno (2003) further suggest that front-line providers also make judgments about the identities and moral character of their clients and, based on these judgments, decide whether a client is “worthy” of a particular state service. While public service workers’ judgments are at times consistent with public policy, at other times front-line providers’ views of fairness and the dictates of the law do not match and street-level bureaucrats consequently struggle to decide what is the right thing to do (Maynard-Moody & Musheno, 2003).

Nurses, like other front-line providers of public services, thus play an important role in implementing (health) policy. In South Africa, the Choice on Termination of Pregnancy Act (CTPA) is one example of a policy where implementation is heavily dependent on nurses. The CTPA, which has been in force for 15 years, allows any pregnant woman or girl to request a

termination of pregnancy (TOP)¹ in the first trimester without consultation or approval by a health care professional (section 2(1)(a) of the CTPA). Abortions in the second trimester are allowed under certain conditions, for instance, if the pregnancy is a result of a rape, if the foetus is at risk for severe mental or physical abnormality or if the pregnancy would significantly affect the social or economic circumstances of the pregnant woman (section 2(1)(b) of the CTPA).

Nurses may be asked not only to assist a doctor or another nurse during the procedure, but also to prepare the patient for the TOP by administering drugs for cervical priming, providing abortion counselling, or obtaining informed consent for the procedure. Nurses may also be requested to assist after the procedure by observing the patient, handing out pain medication or checking for bleeding. In addition, the CTPA allows nurses who have received appropriate training to perform first trimester TOPs by themselves (section 2(2) of the CTPA). This clause was included to promote women's and girls' access to TOPs by making the procedure available at primary level health centres. The law does not, however, introduce a duty to assist or perform abortions; the only legal duty for nurses is to inform pregnant women and girls who inquire about a TOP about their right to have the pregnancy terminated (section 6 of the CTPA).

Research suggests that nurses continue to show reluctance, or are unwilling to be involved in, TOP services, thereby creating an obstacle to the

¹ This article uses the terms TOP and abortion interchangeably.

successful implementation of the CTPA (Harries et al., 2007; 2009; Jewkes et al., 2005). Some nurses have been reported as actively undermining access to TOP services by failing to inform women or girls of the location of the nearest TOP facility or by actively trying to discourage women or girls from going through with an abortion (Harries et al., 2009; Jewkes et al., 2005). Under certain circumstances, however, nurses are supportive of, or even willing to assist in TOPs, for example when a woman or girl has been raped or when the unborn child has congenital abnormalities (Harries et al., 2009; Harrison et al., 2000; Mokgethi et al., 2006). This suggests that value judgments about who is a “deserving” patient may influence nurses’ views of TOPs and possibly their decision about whether or not to participate in TOP services (Walker, 1996). Personal values are shaped by beliefs, ideals and knowledge and they affect not only an individual’s attitudes, but also his or her behaviour (Turner et al., 2008). When making decisions people draw on their values as an “internal roadmap” to guide their actions (Turner et al., 2008). The suggestion that nurses’ behaviour is affected by personal values and attitudes echoes the arguments of the street-level bureaucrats theory that public service workers’ decisions are shaped not only by the rules created under policy, but also by personal beliefs and norms about what is fair and the “right” thing to do (Walker, 1993; Walt & Gilson, 1994; Moulton, 2010).

Using the theory of street-level bureaucrats, we conducted a study on the implementation of the CTPA by exploring nurses’ views and decision-making in the provision of TOP services. The study tests the policy implementation model developed by Maynard-Moody and Musheno (2003) which has thus far

only been applied to teachers, police officers and vocational counsellors in the United States and clerks of the court in South Africa (Maynard-Moody & Musheno, 2003; Moulton, 2010).

Methodology

The study made use of convenience-based sampling. Three districts in the Western Cape province that are within driving distance of Cape Town were selected. The hospitals designated for TOPs in these districts were used as a sampling frame and hospitals from these districts were chosen using a random number generator. Even though the hospitals were only a two to three-hour driving distance from Cape Town, the setting of these hospitals was clearly rural because the geographic character (e.g. landscape, population density) changes dramatically and the availability of health services is limited outside Cape Town. The selected sites are the only hospitals in this environment and serve a large catchment area.

After ethical clearance, the nursing managers or matrons of the selected facilities were informed of the study and asked for permission to conduct an interview with one or two nurses who would be present at the facility on a proposed interview date. Nursing managers thus purposively selected participants for the study according to the availability of staff. Being a provider of TOPs was not an inclusion criterion because all nurses based at hospitals designated for TOPs may be asked to assist in the preparation of the client for the TOP, or during the procedure, and thus need to make decisions about their participation in TOP services. Nevertheless, researchers were only referred to nurses who were – even marginally – involved in abortions. Nurses

opposed to TOPs seemed to be unwilling to participate in the research.² The pre-selection of participants should therefore be considered in the interpretation of the findings. However, this selection process of participants was the only practical way to ensure that the provision of health services was not negatively affected by the research.

Eight face-to-face interviews were conducted in English with nurses at seven hospitals offering TOP services.³ The interviews were semi-structured and guided by a qualitative questionnaire with core questions that allowed for further probing. Based on the methodology of Maynard-Moody and Musheno (2003), participants were encouraged to share a “story” about a TOP client that the participant believed to have influenced their way of thinking about TOP services. The interviews were recorded and transcribed verbatim. The data were analysed using thematic and narrative analysis.

Findings

Sample

The sample included (assistant) nursing managers or matrons (n=5) and professional or registered nurses (n=3).⁴ The duties of nursing managers include administrative tasks and less hands-on work. Their views of routines and the work environment may therefore differ from those of nurses working

² For example, when setting up the interview at one hospital, researchers were told that only the nursing manager conducts TOPs and nobody else at the hospital wants to be involved in it, not even be interviewed about it.

³ This study was part of a larger study assessing nurses' role in the provision of reproductive health care services to teenagers. The thesis research was not limited to teenagers. Although only six interviews were planned for this smaller study an opportunity for two additional interviews presented itself.

⁴ Given that all of the participants trained to be a nurse and used to work as a nurse, all participants will be referred to as “nurse”.

on the wards. Participants had been working in nursing between 14 and 40 years, and five of eight participants had been a nurse for 30 years or longer. Only two of the eight nurses were TOP providers. The other participants were involved in TOPs in various other ways: providing pre-abortion counselling; preparing the client for the procedure by administering drugs for cervical priming; obtaining informed consent for the procedure; and/or assisting during the procedure.⁵

Occupational identity

Nurses have strong views about what it means to be a nurse (Jewkes et al., 1998). To understand nurses' values, judgments and practices in terms of TOP services as well as their relationships with clients, it is therefore helpful to look at how nurses perceive their profession. In our study, only two participants had "always wanted to be a nurse" (WC/02). For the remaining six participants, nursing had not been the first choice, but due to limited job opportunities other professional choices had been unfeasible. However, five of the six nurses who initially preferred a different job identified strongly with being a nurse. They believed that "I was born to be a nurse" (WC/05) and that nursing "is truly my calling" (WL/01) which indicates that participants not only had a sense of being part of the nursing profession, but felt passionately about what they do.

All but one participant spoke positively about their job. They liked nursing because it involves working with people or because of the caring aspect of

⁵ One participant had been actively involved in TOPs when they were introduced at the facility, but at the time of the interview was no longer actively involved in TOPs.

nursing which includes “nurturing” patients (WC/03) and trying “to assist them to get better” (WL/002). Two participants emphasised that caring for patients is very “rewarding” (WL/07) because:

[T]o see somebody that came in sick and walk out of this hospital healthy that is, that’s one of the most fulfilling things especially when it comes to children.
(WL/002)

Two nurses linked the construction of the nursing identity to their views of TOPs. For one nurse the caring aspect of nursing corroborated her support for TOPs:

[F]irst and foremost, I’m a nurse [...] and the day I become a nurse, I’m here to serve the people [...] whatever is wrong with them. (WC/05)

This participant thus stressed that nursing is a selfless profession where the main goal is to “serve the people” no matter what their health problem. However, another nurse felt that the provision of TOPs was inconsistent with her professional identity:

This is not why I went [into] nursing. [...] I went [into] nursing to care for some people, nurture them, try and get them better. (WC/03)

For this participant, nursing is about assisting those patients who are “sick” and women who have an unwanted pregnancy are not sick (WC/03). Thus, despite the shared sense of what nursing is about (i.e. nurturing and caring for

patients), participants interpreted the meaning of their occupational identity differently.

Worthy and unworthy TOP clients

Maynard-Moody and Musheno (2003) argue that public service workers make moral judgments about their clients to distinguish “worthy” clients from “unworthy” clients. Whereas unworthy clients receive standard services, they offer clients whom they consider worthy extraordinary services and support. In our study, both nurses supportive of TOPs (n=6) and nurses opposed to TOPs (n=2) justified their positions by drawing on value judgments and categorised particular clients as more worthy than others.

The need for TOPs

A central argument in support of TOPs was women’s need for the service. Four participants held that there is a need for TOP services with two of them highlighting that teenagers in particular may need a TOP in order to complete their studies. One of the participants felt that TOPs should be offered because it is a “service that [...] the people and the youth need” (WC/05). The understanding of need was, however, clearly shaped by participants’ perception and assessment of the client. For instance, the circumstances or source of the pregnancy played a role when determining whether a client is worthy of support. When asked to share a “story” about a particular client, two participants talked about women who had been forced into the pregnancy and therefore needed a TOP. One participant described the following case:

[I]t was a black woman that came here. And I think it was the first time that I really saw somebody that was raped and [...] abused and that she was

pregnant and that she needed it. And then just her whole – she was desperate. [...] And she was far pregnant. [...] And I could do nothing for her. We could only refer her to Paarl [hospital]. She had no means of transport, no money, no nothing. [...] Ja, totally devastated. (WC/02)

In this instance, the nurse “really saw somebody” whom she felt “needed” a TOP. The rape survivor was clearly not at fault for falling pregnant. She was also very vulnerable (“desperate”) and helpless because she had no support system – she had “nothing”. Another story also highlighted the relevance of the circumstances of the pregnancy:

She was married and had 3 children, she already had 3 children. And she was somebody [from] up country [...] far, far. For almost nine months she was working here and she become pregnant. And she was in a state, real, real [state], you know. And I offer with the [TOP] counselling, I offer her a IUD [i.e. intrauterine device] and that make a world to that lady. [...] I think she also had problems with using contraception because of her husband because he didn't agree with that. And now she had a method [as if] she is not using anything. (WC/05)

This story highlights that contraceptive services are an integral part of TOP services and that nurses consider family planning services as very important. Although the client in this story came for a TOP, the nurse emphasises how she offered the client an intrauterine device, an invisible contraceptive method, which helped the client to escape from the control of her husband. By providing this service, the nurse “made a world” to the client. Similar to the

previous story, the circumstances of the pregnancy are regarded as unfortunate and outside the control of the client. The client's husband "didn't agree with" her using contraception. Another participant also mentioned men controlling women's reproductive rights. She gave the example of women being unable to get sterilised even after having five or six babies "because they're afraid of their husbands" (WL/05). Three participants thus support TOPs in instances where women were unable to make decisions about contraception.

The stories about the rape survivor and the controlling husband illustrate how nurses feel for the clients they consider worthy. Another story confirms that nurses respond empathically to clients whom they consider worthy:

[The woman] was pregnant and she wanted to keep the baby, the pregnancy, she wanted to, but she also had [a] cyst. And the cyst was growing bigger than [...] the foetus. So we did [...] the abortion and she was crying through the whole episode and I was so touched afterwards because here's one lady who really wants to keep the child, but her condition doesn't allowed it.
(WL/07)

Again, the circumstances of the client are tragic circumstances because the client "wanted to" but was unable to keep the "the baby, the pregnancy". These unfortunate circumstances and the client's "crying through the whole episode" moved the participant. Although the participant does not share what she did to comfort the client, the nurse must have been very caring towards

the client because some time after the procedure the client came back to see the participant “just to thank me again” (WL/07).

TOPs as the better alternative

Another factor that nurses discussed in support of TOPs was the implications of women having unwanted babies. Three nurses believed that TOP services were better than having unwanted babies because bringing an unwanted baby into the world is “unfair to the child” (WL/07). Nurses reasoned that due to economic hardship or, in the case of teenagers, immaturity, mothers would be unable to take good care of these babies. The motivation for participating in TOPs was the prevention of poor outcomes for the child. However, not all nurses agreed on this point. One participant’s story about a 19-year old client underlines that he saw unwanted babies in a different light:

[I]n fact, every time I feel that way [...] this fully formed foetus came out and you could see it’s a boy [...] and then when I wanted to clean her up [I saw] there was another boy and I was thinking, my goodness. [...] [T]hat was the saddest part to me because I thought maybe two families or maybe one family could have had these lovely little boys and I didn’t know [because] I didn’t look at the sonar before. So I felt quite sad because [...] everything was so perfect, perfectly formed [...]. I felt very bad that day. (WL/002)

The story demonstrates that this participant – though identifying as pro-choice – is actually conflicted about providing TOPs. He says that he felt “very bad that day”, but in the beginning sets out that “every time” he does a TOP he feels this way. He describes the foetuses as “fully formed [...] lovely little boys” which indicates that he sees them as human beings. The story implicitly

suggests that even for mothers of unwanted babies, there is an alternative to having a TOP: women could have the child and give it up for adoption. The “saddest part” for the participant was that one or two families could have had these babies. In light of his ambiguity about performing abortions, it is not surprising that this participant on the one hand highlighted that “it’s every person’s right” to have a TOP (WL/002), but on the other hand told the researchers that he shows clients baby pictures during the TOP counselling to discourage them from having a TOP.

Abortions are wrong

Two nurses were opposed to the TOP law because having a TOP is simply “not right” (WC/03) thereby expressing a general moral judgment about abortions. Both of them explained that their involvement in TOPs – handing out medication for cervical priming – is “something that I must do, but it’s something that I don’t actually want to do” (WC/03). One of these nurses listed several reasons for not wanting to be involved in abortions. She stressed that TOP clients only have “flimsy excuses” for having a TOP (WC/03). The fact that she believes that a client needs to have an excuse suggests that she does not see TOP as an ordinary health service; instead the client needs to have an acceptable reason for needing a TOP (WC/03). For this participant, abortions may have had a different dimension because “this *is* a life” (WC/03). She therefore interpreted her own involvement in TOPs as “in [inverted] commas ‘murdering’” (WC/03). The participant was thus not only annoyed about women being “careless”, but believed that women are killing the unborn baby and that she as a nurse was forced to participate in the act.

Repeat abortions

Both of the nurses critical of TOPs were particularly concerned about women using TOPs as a form of contraception because “a lot of people, perhaps the older people, [...] come every year [...] for a TOP” (WL/001). This was seen as “careless” and “never-minded” (WC/03). For them, responsible women use contraceptives, and women who use TOPs as a form of contraception are irresponsible. Three of the six participants who were generally supportive of TOP services were also concerned about women coming for repeat abortions. The nurse who believed that women have a right to a TOP added “I only have a problem when it becomes more than once” (WL/002). He told the researchers that “sometimes [clients] come up to six times” and that he “had a school girl here that came in March and had a termination and in May she was here again, in the same year!” (WL/002). Another participant told the researchers:

Sometimes [...] I feel I'm getting the hell in [...] when they come for the third or the fourth [TOP]. (WC/02)

Women coming for repeat abortions make her feel “cross” because they are just “very blasé” about using TOP as “a method of family planning” (WC/02). Another participant supportive of TOPs thought that it is a “little bit frustrating to see teenage girls coming for the second and third times” (WL/01). She added that “you have your own personal feelings” in these circumstances “but there's nothing that one can do about it” (WL/01). All three of these participants emphasised that they would still assist women coming for repeat abortions, but the inappropriate behaviour of these clients clearly frustrated

and angered these providers. In terms of repeat abortions, two of the three pro-choice nurses conceded that only few women have repeat TOPs.

Religious beliefs

Values based on religious beliefs did not determine whether participants were supportive of TOP services. One participant recognised that TOPs conflict with her religious beliefs and acknowledged that she had “mixed feelings” about being involved in TOPs:

I'm a catholic and I'm involved in terminations of pregnancy in the hospital. So that's a big thing for me. (WC/05)

Yet, she reconciled this conflict by highlighting that there is clearly a need for TOPs in her community and that as a nurse “I'm here to serve the people [...] whatever is wrong with them” (WC/05). The two nurses who were not supportive of TOPs, on the other hand, did not refer to religious beliefs. Instead, one of these two nurses stressed that her view is “Nothing [...] about religion” (WC/03).

Insidious moralising

According to Maynard-Moody and Musheno (2003), front-line providers think that they know what is best for the client. Based on their value judgments and practical experience, street-level workers provide often well-intended, yet paternalistic, advice to their clients. Local studies suggest that nurses see themselves as morally and intellectually superior to their patients (Jewkes et al., 1998) and therefore feel they have to “moralise and save the sick”, instead of merely nursing them (Marks, 1994). In our study, paternalistic tendencies

were observed in terms of the TOP counselling. The CTPA stipulates that women requesting a TOP should be offered counselling, but that such counselling is not mandatory to receive a TOP. However, all participants in our study described counselling as an integral step in obtaining a TOP thereby imposing an artificial barrier to getting a TOP.

During the TOP counselling, which includes counselling about contraception, nurses in our study used different approaches to influence their clients' sexual or reproductive behaviour. One participant shows clients baby pictures on a laptop during the TOP counselling. He reported that since he has started showing women these pictures "there's less and less people that come back" for the TOP (WL/002). Other examples of moralising behaviour did not relate to the TOP per se, but to other reproductive decisions. One nurse, for example, stressed that as part of the counselling after the TOP the nurses will "always, always give [the clients] Petogen", the contraceptive injection, because "most people don't remember to take their pills" (WC/03). Another nurse complained that although they provide all their TOP clients with male and female condoms during the TOP counselling and tell them, "you *must* use a condom, it's part and parcel of your life" (WC/05), clients leave the condoms behind in their lockers when they leave the facility. The participant was disappointed and baffled by this behaviour.

Another nurse attempted a subliminal approach to influence her patients. She explained that she will always ask her clients for the name of the baby's father because some clients "don't [even] know the man's name that they have slept

with” (WC/02). Asking for the name of the baby’s father was thus seen as reminding the client that it is immoral to have casual sex with strangers.

Work environment of nurses

Existing literature would predict that day-to-day processes, workloads and the work environment also shape street-level workers’ decision-making and behaviour (Hudson & Lowe, 2004; Maynard-Moody & Musheno, 2003). The findings of this study show that the conditions of services for the nurses in our sample are far from ideal.

Understaffing

A common problem at the facilities was staff shortages. One participant commented at length about how frustrated she was that she could not provide good nursing care due to understaffing:

[T]here’s no time to really sit with somebody, give them any good advice. [...] [E]verything must be rushed. [...] [Y]ou feel sometimes you go off duty and you wonder, “Did I do this? Did I do...?” [...] You just try your best and just hope [...] that everybody survives. (WC/03)

This account clearly demonstrates the challenges nurses face as a result of understaffing. Four additional participants raised the problem of staff shortages at their facility. High workloads may affect the delivery of any health service, but may be particularly relevant when it comes to contentious services such as TOPs. The participant quoted above, for instance, explained that the practice of handing out medication to TOP clients every four hours is too time consuming for nurses. She and her colleagues therefore believe that

“we must give [the medication] to them, but they must take it themselves”
(WC/03). She added:

[W]e feel we are wasting valuable time that you could have spent with a sick person with somebody that didn’t think. [...] Just some days [...] you just feel, ‘Why must we do it?’ (WC/03)

Frustration about TOPs (“Why must we do it?”) may thus be partially caused by high caseloads of patients. Yet, the quote also demonstrates how arguments relating to structural challenges (i.e. understaffing) are coloured by subjective value judgments. This nurse makes a clear distinction between patients who she considers “sick” and TOP patients who, in her opinion, just “didn’t think”. She establishes a hierarchy between these patients by considering sick patients as more deserving of care than TOP patients.

Cooperation with colleagues

In addition to understaffing, this study shows that nurses who provide TOPs operate in an environment where colleagues are not supportive of their work. One participant emphasised that some of her colleagues “hate” the TOP clinic, but that as long as the head of the department and her family supported her, “it really doesn’t bother me if they’re not supportive” (WL/07). While this particular participant does not mind her colleagues’ attitudes, other providers may find it difficult to openly support and work in TOP services in such an environment. The same participant was worried about the lack of cooperation from gynaecologists at the facility who are meant to assist the nurse providers if they run into problems during the procedure:

They will [help us] if they must, [but otherwise] they will say, 'Oh, no, no, no...

You wanna do it, so do it! (WL/07).

Being worried about getting the necessary medical support from colleagues can put a lot of tension on nurse providers. This participant is aware that she is on their own when performing TOPs unless there is a serious medical emergency.

Another participant believed that the attitudes towards TOPs at her facility were "very negative" which is evidenced by the fact that only one Sister is available to assist the doctor during the procedure (WL/05). Scarcity of staff willing to provide or assist in TOPs was also a problem at other facilities. Although one participant believed the staff at her facility are comfortable with TOPs, the TOP procedure at this hospital is outsourced to staff from the local clinic: A trained Sister and a nurse, who usually work at the local clinic, come to the hospital to offer TOPs. Except for the nurse who participated in the interview, none of the nurses or doctors at the facility are actively involved in TOPs.

Another participant emphasised that he and another nurse, the only TOP providers at the facility, "really don't get looked at funny [...] anymore", not like in the beginning when "all the nursing staff thought we are big murderers [...] and they said it" (WL/002). He described the theatre staff as "very supportive", but believed that the true motive behind this support is that as long as the

colleagues support him they can be sure that they do not have to provide TOPs themselves (WL/002). The lack of support for TOPs among other hospital staff was further illustrated by the fact that TOP clients “get a lot of flack” when presenting at the casualty department of his facility on the day of the procedure (WL/002). On the one hand, the participant believed that this was unacceptable and therefore introduced a complaint mechanism for clients. On the other hand, he said that he does try “to accommodate” colleagues in casualty who are against abortions by sending them for stocktaking on the day when TOP services are offered.

Two participants believed that their colleagues were generally supportive of TOPs; just the odd one would say that TOPs are not within her “scope of practice” (WC/05) “one or two [...] might be totally against” TOPs for religious reasons (WC/02). However, a second interview at one of these facilities revealed that “what is building up [among all the nurses] is sometimes a sort of resentment” about TOPs (WC/03). Overall the data show that at at least five of the seven facilities where the interviews were conducted, nurses providing TOP services work in an uncooperative environment and only limited staff is available to perform or assist in TOPs.

Discussion

This study suggests that nurses, like other street-level bureaucrats (Maynard-Moody & Musheno, 2003; Moulton, 2010; Walker, 1993), make moral judgments about the character of their clients. Based on these judgments, they consider certain TOP clients as more worthy of support than others. Despite the limited

generalisability of the findings, the study provides valuable insights for understanding nurses' decision-making in relation to the CTPA.

Like other street-level workers, nurses do not see themselves as working for the management or the state (Maynard-Moody & Musheno, 2003); they act on behalf of their clients, working for people is their "calling". Similar to the finding of Maynard-Moody and Musheno (2003), who suggest that occupational identity can be interpreted differently within a group of street-level workers, the participants in our study shared a strong sense of occupational identity, but in terms of TOP services interpreted the meaning of this identity differently. While some nurses saw the purpose of nursing in serving the people "whatever is wrong them", another nurse felt that providing TOPs "is not why I went [into] nursing". For her, nursing is about caring for people who are sick and women requesting TOPs are not sick, they just "didn't think". Value judgments thus penetrate nurses' occupational identity and may shape their view of TOP services.

Street-level workers such as police officers and vocational counsellors determine whether a client is worthy of support by assessing a client's need (Maynard-Moody & Musheno, 2003). In our study, nurses supportive of TOPs also justified their position by clients' need for TOPs. Adults and teenagers require TOPs because otherwise they would be forced to have unwanted babies, which was perceived as "unfair to the child". TOPs are therefore not only in the interest of the pregnant woman, but also in preventing a child having to grow up in an emotionally and socio-economically deprived

environment. However, nurses who consider the unborn baby as “a life” struggle with this justification for TOPs. The story about the twins illustrates how the participant felt “sad” and “bad” about aborting two “lovely little boys” who were “perfectly formed”. This nurse feels uncomfortable about performing TOPs because he sees the foetus as a human being. Furthermore, reading between the lines, the story suggests that it is not fair that TOP clients like the 19-year old girl abort healthy babies whereas other people are unable to have children. He believes that women should not abort babies, but rather give them up for adoption. While his view did not affect his decision to perform TOPs, this participant attempts to resolve his moral dilemma by showing clients baby pictures during the TOP counselling to encourage them to keep the baby. The participant does not refuse to perform a TOP, but he adapts his implementation routine by trying to discourage clients from having a TOP.

Similar to the findings of Maynard-Moody and Musheno (2003), genuine need by itself is not or at least not always enough to establish the “moral worth” of a client. Another relevant determinant is the reason for or source of a client’s problem (Engelbrecht, 2005; Maynard-Moody & Musheno, 2003). The narratives from the nurses in our sample confirm that the circumstances of a pregnancy influence whether a woman is regarded as a deserving patient. Where the pregnancy is the result of coercive circumstances the clients are clearly seen as worthy of support because they are not at fault for the pregnancy. This finding echoes earlier research showing that the circumstances of the pregnancy influence nurses’ support for TOPs (Harries et al., 2009; Harrison et al., 2000; Mokgethi et al., 2006). The clients who

were raped or were unable to use contraception because of their husbands were viewed very differently from other patients. Nurses constructed these clients as “desperate”, “totally devastated” and “in a real state” which means they were in an emergency situation and thus worth of support. Speaking about the rape survivor the nurse “really saw [...] that she needed” the TOP – a characterisation which is clearly contrary to women who have “flimsy excuses” for requesting a TOP. Patients who are perceived as vulnerable and in a real crisis thus receive an empathetic response from nurses. Perhaps vulnerable clients respond better to nurses’ perception of their professional identity. Where a patient is in crisis, the help of a nurse can have the biggest impact. For example, by offering her client an intrauterine device, a contraceptive method that was beyond the husband’s control, the nurse could “make a world” for her patient.

Women coming for repeat abortions were described as “careless”, “never-minded” and “blasé” and were thus unworthy clients. These clients make nurses feel “cross” and frustrated. The fact that these clients, too, need a TOP is irrelevant. Neither did nurses consider that there may be good reasons why these clients return for repeat abortions. The resentment towards women requesting repeat abortions, which has been reported in previous studies (Engelbrecht, 2005; Harries et al., 2009; Mokgethi et al., 2006), illustrates that nurses believe that a TOP should be a last resort. For them, TOPs are not only justifiable for emergencies or crises, they also accept them for a one-time slip-up. Yes, women have the right to have a TOP, but just *one* TOP. After one TOP, clients need to behave responsibly and take precautions. There is

no justification for another TOP given that nurses provide clients with family planning as part of the TOP counselling. For nurses, the right to have a TOP has its limits.

Like the street-level workers in Maynard-Moody and Musheno's study, nurses believe that they know what is best for their clients (Maynard-Moody & Musheno, 2003). Paternalistic tendencies of the participants were evidenced by their views on TOP counselling. First, nurses in our sample stressed that every TOP client receives TOP counselling. Whereas such counselling is optional under the CTPA, it was standard procedure at the sampled facilities. Requiring patients to go through such counselling is another example of nurses applying their own value judgments: they believe that it is important to make clients aware of the alternatives to having a TOP and therefore all patients are counselled before the TOP.⁶ Although the CTPA envisages counselling to be optional, nurses make it a standard procedure. Further, during the TOP counselling, nurses discuss family planning with their TOP clients and give them contraceptives. One nurse advises her clients to use the contraceptive injection because clients forget to take the pill. Another nurse provides clients with condoms and tells them that they "must use condoms". Similar to Marks' (1994) suggestion that nurses attempt to moralise their clients, participants in our study tried to influence their clients' reproductive behaviour and expected them to follow their advice. Clients who come back for a repeat abortion may thus be perceived as disobedient; they challenge

⁶ Participants were, however, not asked what would happen if a client refused to undergo such counselling. It is therefore possible that clients could refuse the counselling.

the nurses. This may be another reason why nurses perceive women coming for repeat abortions as less worthy of support.

Maynard-Moody & Musheno suggest that public-sector workers provide standard services to standard clients, but if they consider a client worthy, front-line providers will go beyond their regular mode of response and provide extraordinary services (Maynard-Moody & Musheno, 2003). Street-level workers' concept of fairness allows them to treat clients differently according to their perceived worth (Maynard-Moody & Musheno, 2003). Based on the accounts of the participants in our study, the services offered to clients considered worthy or not worthy do not differ. The participants in our study claimed, for instance, that they do not deny TOP services to women who return for repeat abortions. On the other hand, they also did not give examples of nurses going beyond their standard obligations for clients whom they considered worthy. Given that our study did not examine the level or quality of TOP services received by clients, the statement of the participants need to be taken at face value. Future research should therefore investigate whether all clients – those considered worthy and those considered less worthy – can access TOP services and whether there are differences in the quality of services. It is also important to note that the finding of participants claiming to provide the same service to all clients may be influenced by our sample which was limited to nurses who were providers of TOPs, or TOP counselling, or were at least marginally involved in assisting in TOPs; six of the eight nurses identified as pro-choice. It is therefore possible that these nurses feel that since they have decided to assist in TOPs, they will just stick

to their decision, even if they consider certain clients as less worthy. Future studies should investigate the decision-making of nurses who are opposed to TOPs and/or refuse to provide any assistance in TOPs.

While the services may have been the same, the emotional response towards deserving patients and undeserving patients was very different. The stories about the rape survivor and the TOP client who wanted to keep her baby clearly touched the providers. This demonstrates that nurses, like other street-level workers, do not see their clients as “abstractions” (Maynard-Moody & Musheno, 2003), they take their clients’ stories to heart. Nurses remember stories about patients they consider worthy – the rape survivor, the woman who could not keep her baby, the client whose husband did not allow her to use contraceptives – because they feel for these clients. The nurses felt empathetic and caring towards patients whom they consider worthy. Whether the differences in emotional responses have an impact on the quality of service rendered to TOP clients was not investigated in this study, but this is certainly a question that warrants further investigation.

Nurses’ views and decision-making in terms of TOP services should also be seen in light of their work environment. Nurses have to manage high patient loads at hospitals that are understaffed. Some of the resentment and unwillingness to participate in TOP services may therefore be rooted in nurses feeling overburdened. Nurses feel they are “wasting valuable time” and wonder “Why must we do it?” The frustration about women coming for repeat abortions may therefore also be (partially) caused by the added workload that

these patients cause. Nurses may perceive women coming for repeat abortions as obstacles to effectively managing their workload.

Another structural challenge is the lack of support for TOPs among nurses' colleagues. Participants highlighted that some colleagues hate the provision of TOPs and refuse to get involved in TOP services. The lack of support for TOPs has various negative implications for nurses and nursing managers. As illustrated by the participant who removes certain members of staff from the casualty department on the day of TOP services, lack of support among colleagues may create an additional workload for managers. For providers, even if they did not report being harassed or stigmatised by colleagues, working in an environment where colleagues disapprove of their work may lead to feelings of isolation and tension which may jeopardise their willingness to provide TOP services long-term (Harries et al., 2009).

The lack of support from colleagues also makes it difficult for managers to find replacements if the staff member who usually assists in TOPs is unavailable (e.g. leave; sick-leave; training). Those who do assist in TOPs also carry the burden of being the only, or one of a few, providers. Nurses who decide to perform or assist in TOPs face high caseloads of TOP clients which may lead to burnout, particularly if providers feel ambiguous about providing TOPs in the first place (Harries et al., 2009). Research suggests that value-clarification workshops can lead to a change in attitudes towards TOPs among hospital staff (Mitchell et al., 2008; Turner et al., 2008). More research is needed to confirm whether offering these workshops to hospital staff can create a more

conducive work environment for providers and increase the number of staff willing to assist in TOPs.

Limitations

The study may have several limitations. It is based on a small sample of nurses who provide or assist in TOPs. The norms and values of nurses supporting TOPs may be very different from the norms and values of nurses who refuse to be involved in TOP services. Future research should therefore attempt to focus on nurses who refuse to be involved in TOP services. While participants in this study emphasised that services would be the same, whether they considered a client worthy of support or not, the quality of services provided to clients was not assessed in this study and should be investigated in future research. Furthermore, this study drew heavily on narratives which may not always provide a full understanding of participants' views or experiences.

Conclusion

As front-line providers, nurses play an integral role in the implementation of the CTPA. This study among nurses involved in TOP services at rural hospitals in the Western Cape suggests that nurses make moral judgments about TOP clients thereby dividing them into deserving and less deserving clients. Nurses believe that there is a real need for a TOP if the pregnancy was forced upon the client and the clients is therefore “desperate” and “devastated”. These constructions of worthy clients were in contrast to constructions of “careless” and “never-minded” clients who come for repeat abortions. Other expressions of value judgments were found in nurses’ –

generally insidious – moralising behaviour towards TOP clients during the TOP counselling. Nurses believe that they know what is best for their clients, whether it is keeping a baby or using a certain method of contraception. Clients who return to the hospital for a repeat abortion may be constructed as blatantly ignoring nurses' advice which makes them less worthy of support.

However, our study did not find that nurses' value judgments shaped their decision about whether or not they would provide TOP services. Participants emphasised that TOP services were offered to all clients requesting them – whether they as nurses considered these clients worthy or unworthy. This finding should, however, be interpreted with caution because our study did not examine service delivery. Furthermore, all of the nurses in our sample were actively involved in TOP services and six of the eight nurses identified as being pro-choice. It would be useful to examine the decision-making of nurses who are anti-choice or refuse to be involved in TOP services. While the nurses in this study reported that services for patients whom they consider worthy and unworthy are the same, the emotional response to patients perceived as deserving or undeserving was clearly different. The experiences of clients, for instance the client who had been raped and the client who wanted to keep her baby, clearly touched the providers. This demonstrates that nurses take the experiences of their clients to heart which raises questions about potential differences in the quality of services provided to deserving and undeserving TOP clients.

Further, the study raises concerns about nurses' work environments. In particular, the scarcity of colleagues supportive of TOPs make the work of nurses who perform or assist in TOPs very difficult. In order to prevent burn-out of these nurses, the Western Cape Department of Health should consider the roll-out of interventions such as value-clarification workshops for all staff.

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Appendices

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Appendices

Appendix A:	Interview questionnaire
Appendix B:	Participant information sheet and consent form
Appendix C:	Approval from the University's Research Ethics Committee
Appendix D:	Social Science & Medicine: Guidelines for Authors

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Nurses' Decision-Making in Termination of Pregnancy Services at Health Care Facilities in the Western Cape

Interview Schedule

The first questions I have are about yourself and your job generally. In the second part of the interview I will ask you some questions about abortions and how you feel about conducting or assisting in abortions. I will also ask you to think of a “story”, an incident that you recall, either from your own experience or one of your colleagues experiences, where a woman or girl requested an abortion and how this incident affected you.

1. How long have you been working as a nurse?
2. What made you decide to become a nurse?
3. Could you describe what a “usual” workday looks like from when you arrive at work until you go home?
4. What do you like about your job?

The next questions are more related to providing abortion and abortion-related health care.

5. From what age can a girl consent to having a termination of pregnancy?

6. If a woman or girl comes to this facility and asks for an abortion – what is the process/what will happen?
7. Do you assist in terminations?
8. What is your role in this process?
9. What do you think are some of the reasons why teenage girls request a termination of pregnancy?
10. Why do you think some teenage girls do not use condoms or birth control?
11. The law says that anyone can have a termination of pregnancy up to 12 weeks of gestation. How do you feel about this law?
12. (Select provider/non provider) Are there any circumstances under which you would not assist/assist in a termination of pregnancy? Please explain.
13. What are the challenges you face when providing termination of pregnancy services to teenagers?
14. How do you think your colleagues at this facility feel about termination of pregnancies for teenagers?
15. Could you tell me a story about one particular patient or one particular experience you had in relation to TOP that stayed with you or that shaped your views on TOP?
16. Is there anything you'd like to add about what we've just talked about?

Nurses' Decision-Making in Termination of Pregnancy Services at Health Care Facilities in the Western Cape

Participant Information Sheet

You are invited to take part in a research study. Before you decide to be a part of this study, you need to understand the risks and benefits. This information sheet provides information about the research. The interviewer of the study will be available to answer your questions and provide further explanations.

Before you learn about the study, it is important to know the following:

- Your decision to take part in this study is voluntary;
- You may decide not to participate or to withdraw from the study at any time without penalty.

INTRODUCTION TO PERSON BEING INTERVIEWED:

1. I am conducting a study that looks at nurses as service providers for abortion care. This study is part of my degree (Masters of Public Health) and is not conducted in collaboration with the Department of Health.
2. I am interested to learn more about the provision of abortions at this health care facility. I would like to find out how nurses make decisions about assisting in abortions and implementing the policy on abortion.
3. If you decide that you would like to participate in this study, I will ask you questions about:
 - a. your experiences as a nurse working at this facility;
 - b. your role and responsibilities in providing abortion care;
 - c. challenges you experience in your day-to-day work.
4. The interview is "once-off" only and will take approximately 45 minutes.

5. Everything you tell me is for research purposes only and will be kept strictly confidential. Your name and personal details as well as the name of the health facility where you work will not appear in any report or document.
6. You will not get any personal benefit or compensation from taking part in this study. There are no costs associated with taking part in this study. The study will help us to better understand nurses' perspectives and experiences in abortion care. The aim of the study is to feed nurses' experiences back into policy.
7. This is not a test and you will not be penalised for any answers that you provide.
8. If you have questions about the procedures of this research study, please contact Steffi Roehrs by telephoning 082 7309337 during office hours.
9. If you have any concerns about your rights and welfare as research subjects, please contact the Human Research Ethics Committee at the University of Cape Town by contacting Ms. Lamees Emjedi on 021 406 6338 or via Email lamees.emjedi@uct.ac.za
10. You may ask me any question about the research and I will answer you honestly. Do you have any questions?
11. If you agree to participate, please complete the consent form.

Nurses as Street-Level Bureaucrats: Decision-Making in Abortion Services and Care

Consent Form

1. I understand the purpose of the research.
2. My involvement in this study has been fully explained to me.
3. I understand that my participation is voluntary and that I have the right to withdraw my consent or discontinue the interview at any time without penalty or prejudice. I have the right to refuse to answer any question(s) without giving an explanation or saying why.
4. I freely consent to participate.
5. I freely consent that the interview is going to be recorded.

Date:

Signature Participant:

Name of field worker:

I declare that I handed out the information form to the participant and answered the participant's questions to my best knowledge.

Date:

Signature Fieldworker:

Appendix C.: Approval from the University's Research Ethics Committee¹

University of Cape Town

¹ Please note that this study was part of a larger study. The ethical clearance therefore refers to the larger research study.



UNIVERSITY OF CAPE TOWN

Faculty of Health Sciences
Faculty of Health Sciences Research Ethics Committee
Room E52-24 Groote Schuur Hospital Old Main Building
Observatory 7925
Telephone [021] 406 6338 • Facsimile [021] 406 6411
e-mail: sumayah.ariiefdien@uct.ac.za

20 September 2011

HREC REF: 402/2011

Dr K Moul
Clinical Lab Sciences
Div of Forensic Medicine & Toxicology
Falmouth Building

Dear Dr Moul

PROJECT TITLE: CONDOMS? YES! SEX? NO! CONFLICTING RESPONSIBILITIES FOR HEALTH CARE PROFESSIONALS UNDER SOUTH AFRICA'S FRAMEWORK ON REPRODUCTIVE RIGHTS.

Thank you for submitting your study to the Faculty of Health Sciences Human Research Ethics Committee for review.

It is a pleasure to inform you that the Ethics Committee has **formally approved** the above-mentioned study.

Approval is granted for one year till the 30 September 2012.

Please submit a progress form, using the standardised Annual Report Form (FHS016), if the study continues beyond the approval period. Please submit a Standard Closure form (FHS010) if the study is completed within the approval period.

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Please quote the REC. REF in all your correspondence.

Yours sincerely

PROFESSOR M BLOCKMAN
CHAIRPERSON, HSF HUMAN ETHICS

Federal Wide Assurance Number: FWA00001637.
sAriefdien

Institutional Review Board (IRB) number: IRB00001938

This serves to confirm that the University of Cape Town Research Ethics Committee complies to the Ethics Standards for Clinical Research with a new drug in patients, based on the Medical Research Council (MRC-SA), Food and Drug Administration (FDA-USA), International Convention on Harmonisation Good Clinical Practice (ICH GCP) and Declaration of Helsinki guidelines.

The Research Ethics Committee granting this approval is in compliance with the ICH Harmonised Tripartite Guidelines E6: Note for Guidance on Good Clinical Practice (CPMP/ICH/135/95) and FDA Code Federal Regulation Part 50, 56 and 312.

University of Cape Town

Appendix D.: Social Science & Medicine: Guidelines for authors

University of Cape Town



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Social Science & Medicine provides an international and interdisciplinary forum for the dissemination of social science research on health. We publish original research articles (both empirical and theoretical), reviews, position papers and commentaries on health issues, to inform current research, policy and practice in all areas of common interest to social scientists, health practitioners, and policy makers. The journal publishes material relevant to any aspect of health from a wide range of social science disciplines (anthropology, economics, epidemiology, geography, policy, psychology, and sociology), and material relevant to the social sciences from any of the professions concerned with physical and mental health, health care, clinical practice, and health policy and organization. We encourage material which is of general interest to an international readership.

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- 2) Peer-reviewed short reports of findings on topical issues or published articles of between 2000 and 4000 words.
- 3) Submitted or invited commentaries and responses debating, and published alongside, selected articles.
- 4) Special Issues bringing together collections of papers on a particular theme, and usually guest edited.

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Authors should approach the Managing Editor if they wish to submit companion articles.

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We accept most word processing formats, but MSWord files are preferred. All author-identifying text such as title pages and references must be removed. Submissions should be double spaced and use between 10 and 12pt font, and any track changes must be removed.

It is important that the file be saved in the native format of the original wordprocessor used. The text should be in single-column format. Keep the layout of the text as simple as possible. Most formatting styles will be removed and replaced during typesetting. In particular do not use the wordprocessor's options to justify or to hyphenate words. However, do use bold face, italics, subscripts, superscripts etc. Do not embed "graphically designed" equations or tables, but prepare these using the wordprocessor's facility. When preparing tables, if you are using a table grid, use only one grid for each individual table and not a grid for each row. If no grid is used, use tabs, not spaces, to align columns. The electronic text should be prepared in a way very similar to that of conventional manuscripts (see also the Guide to Publishing with Elsevier: <http://www.elsevier.com/guidepublication>). Do not import the figures into the text file but, instead, indicate their approximate locations directly in the electronic text and on the manuscript. See also the section on [Electronic artwork](#).

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Authors should retain an electronic copy of their manuscript.

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The Cover Page should **only** include the following information:

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In the main body of the submitted manuscript this order should be followed: abstract, main text, references, appendix, figure captions, tables and figures. Do not place tables and figures in the main text. Author details, keywords and acknowledgements are entered separately during the online submission process, as is the abstract, though this is to be included in the manuscript as well. During submission authors are asked to provide a word count; this is to include ALL text, including that in tables, figures, references etc.

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